Balster Pediatric Dentistry

4150 Edgewood Rd NE Ste 250 Cedar Rapids, IA 52402

PATIENT INFORMATION:

_____

First Name Last MI

Preferred name: _____

Birth Date: _____ Age: _____

Social Security: _____

BROKEN APPOINTMENT POLICY

A broken appointment is when a patient fails to give 24 hrs notice of cancellation or simply does not show up for an appointment. After two broken appointments you will need to seek dental care elsewhere.

AUTHORIZATION:

I understand that I am responsible for all charges incurred by me or my family regardless of insurance coverage and that **PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED.** If my account requires servicing by a collection agency or by an attorney I understand that I will be liable for the collection fees, attorney fees, legal fees, interest and applicable court costs, in addition to my outstanding balance. I also request that payment under my dental insurance program be made directly to Balster Pediatric Dentistry on any unpaid bills for services furnished me or my family. I authorize the release of any dental information necessary to process this claim and all future claims.

Signature: _____

Date: _____

RESPONSIBLE PARTY (WE WILL NOT BILL A THIRD PARTY):

This must be the Guardian bringing patient to appointment

First Name: _____ Last Name: _____ MI: _____

Address: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ ext. _____

Cell Phone: _____ Preferred Number: Home Work Cell

Birth Date: _____ Social Security: _____

Relationship to Patient: _____

Emergency Contact Name and Number: _____

PRIMARY INSURANCE:

_____

Name of Policyholder

_____

Social Security/ Policy ID Birth Date

_____

Employer & Dental Insurance Carrier

SECONDARY INSURANCE:

_____

Name of Policyholder

_____

Social Security/Policy ID Birth Date

_____

Employer & Dental Insurance Carrier

The permission of a parent or guardian is necessary for dental treatment of a minor:

I give the doctors permission to use such measures as deemed necessary in their professional judgment to render a diagnosis for my child. This would include an oral examination, radiographs (x-rays) and other diagnostic aids. I have given an accurate report of my child's physical and mental health history. I have also reported any prior allergic or unusual reactions to drugs, food, insect bites, anesthetics, pollens, dust, blood or body diseases, gum or skin reactions, abnormal bleeding or any other conditions that my child's medical doctor has advised me should be reported to a dentist.

_____

Signature Date

_____

Reviewed By Office Date